POWERLESSNESS PERCEPTION AND PREVENTIVE HEALTH BEHAVIOR OF GERIATRIC INDIVIDUALS

A THESIS

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We hereby recommend that the thesis prepared under our supervision by Paula Ann Key Loftis, B.S.N., R.N. entitled Powerlessness Perception and Preventive Health Behavior of Geriatric Individuals be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

Committee:

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

Dedicated

to the memory of

my mother

Jackie Ella Futch Key

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CHAPTER 1

INTRODUCTION

Today, 11% of the American population, or approximately 1 of every 10 persons, is 65 years of age or older. It is estimated that by the year 2030, this number will increase to 20% (U.S. Public Health Service, 1980b). Most individuals who are 65 years of age or older report themselves to be in good to excellent health (Botwinick, 1973; Brown, Haas, & Stevens, 1978); however, there are specific health problems that are underreported. These problems are frequently contributed to "old age" rather than disease entities (U.S. Public Health Service, 1980a). Many of these problems could be treated, ameliorated, or even resolved with early detection and preventive health care. Debilitation and physical crisis frequently deprive the elderly of independence and dignity, resulting in costly hospital expenses and rehabilitative services (Growing Old, 1976).

Whether a geriatric individual's sense of control has a direct correlation to behavior was a question of interest in this particular study. Age, as a

variable, is not usually studied separately, but is controlled for in most studies of powerlessness. Factors influencing the course of aging are so intricately intertwined that it is practically impossible to separate such factors for study. Knowledge of specific age changes and attitudes of the geriatric population is necessary for nursing to identify individual patient needs and plan appropriate intervention.

Problem of Study

The problem of this study was to investigate the relationship between the perception level of powerlessness of geriatric individuals and their reported preventive health behaviors.

Justification of Problem

In the health care setting, nurses join with other health care providers to perform the function and role of health care delivery. Continuing problems in health care are (a) increasing consumer requirements for participation and services, (b) illness and crisis approach, (c) expanding health care costs, (d) fragmentation of services, (e) poor apportionment of manpower and facilities, and (f) lack of consistency in health

care systems (Kark, 1974; Trends Affecting the U.S., 1975). Rapid development and expansion of health services, along with a flourishing of various kinds of specialists, are factors which have led to confusion for the consumer.

Patients as well as families are in crucial need of an individual to provide support during crisis, to mobilize and coordinate the myriad of services and resources, and to advocate on their behalf (Hinsvark, 1974; Lambertson, 1974). The medical profession gives minimal attention to prevention of disease and promotion of health. The nursing role and interest in both of these areas is significant. Nursing focus is on positive health and providing assistance within the health care system (Hinsvark, 1974). Nursing emphasis, through expanded functions and roles, is based on meeting the needs of the populace for improved health care (Carser & Doona, 1978; Hinsvark, 1974). There is a growing importance and need in the family and community for disease prevention, health promotion, and health maintenance.

The study of attitude, or perceived attitude, is of significance to nursing in correlation to health

behavior. The role of powerlessness in health behavior in the elderly has not been specifically reported by nursing or the sociopsychological field. The feeling of powerlessness in the elderly and the inability to change either themselves or their situation, may be reflected in attitude or sense of control in their lives. This powerless attitude may be expressed as fear, bitterness, or hopelessness, and may lead to malignant apathy. The elderly may deny reality and fail to accept responsibility for their actions or self-care. In a severe apathetic state, confidence is diminished, relationships are misconstrued, and interest in daily chores is often lost (Seeman, 1959, 1972).

All living people grow old. Although this statement ostensibly is trite, there are indications that society is still far from a philosophical and cultural acceptance of aging. Paradoxically, society endeavors to extend longevity and forestall death. Wider interdisciplinary involvement is needed in planning an environment to provide for the elderly. Research findings alter the predisposition of health care providers to view aging as equivalent with ultimate disability and

overall deterioration (Botwinick, 1973). Determination of those components in aging that are not age-specific, and hopefully accessible to change, can revive emphasis on early detection and prevention of disease processes contributing to diminished health.

A major goal of the community health nursing profession is rooted in the principles of prevention, control, and the preservation of health and life to an optimal level (Freeman, 1970). Primary prevention activities refer to the promotion of an active state of positive health which involves promotion of optimal life situations prior to the stage of problem or symptom development. These activities also include specific forms of protection against particular stressful factors (Neuman, 1974).

Nursing can provide an active preventive and rehabilitative role in the care and education of the elderly. In this role, nursing is supportive of the elderly in promoting participative decisions, reinforcement of the individual's involvement in society, and self-responsibility (Carser & Doona, 1978; Otto & Featherman, 1975). Nursing's goal regarding the elderly is more realistically aimed at emphasis on a

higher quality of life rather than simply on a longer life span (Dunn, 1961).

Conceptual Framework

The concept of powerlessness utilized in this study is a component of alienation. In the 1960s, alienation appeared as a significant psychosocial concept (Seeman, 1971). Alienation can exhibit testable factors in the following three areas: (a) historically based report on contemporary social conditions, (b) statement regarding psychological outcomes of the social setting, and (c) forecast of individual behavior (Seeman, 1972). The third area is the main concern of the present study; i.e., the relationship of powerlessness to behavioral consequences and action.

Powerlessness is the most commonly accepted meaning of the concept alienation. Powerlessness, as defined by Seeman (1959), is "the expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes, or reinforcements, he seeks" (p. 784). Powerlessness as identified by Seeman (1959) is closely related to Rotter's (1966) internal versus external control of reinforcements. The powerless

individual has a generalized sense of an inability to control his own destiny (Seeman, 1971). The individual feels that control is rooted in external forces, powerful others, fate, or luck (Seeman, 1972). Seeman (1972) further described the powerless individual as "not likely to engage in planned, instrumentally oriented action" (p. 478).

Powerlessness can be characterized by a lack of the values of mastery and autonomy. The sense of powerlessness contributes to attitude, behavior differences, and unpredictability of an individual's life. As a subjective state, powerlessness will vary and produce individual perceptions and levels of powerlessness (Seeman, 1972).

The importance of distinguishing between generalized and specific powerlessness, as well as personal and ideological control, has been identified in the literature. Distinctions between personal and ideological control have also been identified. Personal powerlessness is associated with individual intentions or aims such as love and work achievement. Ideological or social powerlessness engages in problems of a different dimension, such as those found in the economic status

of the country, international relations, or similar subjects (Seeman, 1972). The present study focused on personal control and specific powerlessness.

Symptoms of powerlessness can be identified as insecurity, confusion, and restlessness. Once-honored rules may no longer seem significant and once-cherished goals may no longer seem reachable; while no other rules or goals seem worth the effort. However, powerlessness should not be misinterpreted as a measure of personality adjustment (Seeman, 1959).

An individual should not be viewed as maladjusted if he/she has a feeling of low expectation of attaining a personal reward. Seeman's (1959, 1972) interpretation of powerlessness did not delineate the disappointment or cognitive dissonance an individual may encounter as a result of the importance of control to the individual, such as control expected or attained and control desired. Seeman (1959) suggested that

> the individual's expectancy for control of events is clearly distinguished from (a) the objective situation of powerlessness as some observer sees it, (b) the observer's judgment of that situation against some ethical standard, and (c) the individual's sense of discrepancy between his expectations for control and his desire for control. (p. 784)

Seeman and Evans' (1962) study of patient learning in a hospital setting focused on the behavioral aspect of powerlessness and noted that powerlessness perception correlated to knowledge acquisition, attitude, and response. High powerlessness related significantly to limited knowledge and diminished value of advancing knowledge related to powerless feeling individuals who felt outcomes were controlled by luck, chance, or other external forces (Seeman & Evans, 1962). Thus, the individual's sense of powerlessness affected response and behavior outcomes as related to health and work.

Seeman's (1959, 1967a, 1971, 1972) studies examined powerlessness in social situations and its behavioral consequences, expectations, and values. These studies provided the framework for understanding and utilization of powerlessness in the present study. Seeman also noted the distinctive impact of powerlessness on the characterization of American life and values and, therefore, supplies the concept with relevance to this study.

Assumptions

For the purposes of this study, the following assumptions were made:

1. Self-perception is attributed to social learning and experience.

2. There are individual variances in powerlessness perception.

Hypothesis

The following hypothesis was proposed:

There will be no significant relationship between perception level of powerlessness and reported preventive health behavior of geriatric individuals.

Definition of Terms

For the purposes of this study, the following terms were defined:

1. Powerlessness--component or alternate meaning of the concept alienation. It is the expectancy or probability held by an individual that one's behavior cannot determine the occurrence of outcomes of reinforcements sought (Seeman, 1959).

2. Perception level of powerlessness--an individual's self-impression of the degree of

powerlessness which was indicated by a score on the Health-Illness Questionnaire. Items 1-10 of the questionnaire are indicative of powerlessness. A higher score indicated a higher perception level of powerlessness.

3. Geriatric individual--an individual, male or female, of 65 years of age or older.

4. Preventive health behavior--advance measures and actions taken by an individual directed at preservation of the individual's well-being or level of wellness. This behavior was indicated by a score on the Health-Illness Questionnaire. Items 11-20 of the questionnaire are indicative of preventive health behavior. The higher the score, the more reported preventive health behavior.

Limitations

The limitations of this study were as follows:

1. The instrument was a self-report instrument and findings were contingent upon the veracity of the subjects.

2. Ethnic background and socioeconomic status varied according to setting.

3. Previous or present organizational membership may have been an influence on an individual's perception level of powerlessness.

4. There were individual differences in interpretation of health.

5. The sample consisted of volunteer subjects selected by the convenience method.

Summary

A criterion of growth in nursing consists of expanding professional knowledge (Freeman, 1970). The present study proposed to increase the awareness of nursing in relation to knowledge and understanding of the concept of powerlessness in the elderly. The expansion of knowledge in this area is indicated in the face of a void of studies addressing the preventive health behavior of the elderly and possible antecedents to this behavior. The improvement of nursing practice, the system of care delivery, and education necessitates the development and testing of hypotheses to advance and contribute to theories for practice in nursing (Tinkham & Voorhies, 1977).

The problem pertinent to this study was defined as the comparative assessment and analysis of the perception

level of powerlessness of geriatric individuals and preventive health behavior. Statements have been made demonstrating the relevance of powerlessness perception to preventive health behavior in this study. The significance and role of powerlessness to preventive health behavior, quality nursing care, and understanding of the geriatric individual have been delineated as justification of the problem and study. The conceptual framework of Seeman was implemented in presentation of the concept of powerlessness. Assumptions, definitions, and limitations relevant to this study have been identified and characterized.

CHAPTER 2

REVIEW OF LITERATURE

This chapter of the study includes research and literature in the areas of powerlessness, alienation, and the effects of powerlessness and alienation on society and the individual. Mass society theory, preventive health behavior and the elderly, and attitudes and beliefs literature review are also covered in this chapter.

Historically, alienation has been employed in the social psychology field to describe and define man's social behavior. There are multiple definitions of alienation and a major component of these definitions is man's feeling of a lack of power. Alienation as powerlessness is linked to Marx's (cited in Seeman, 1959) sociological view concerning capitalist society and the worker's status in the industrial system.

> What constitutes the alienation of labour? First, that the work is external to the worker, that it is not part of his nature; and that, consequently, he does not fulfill himself in his work but denies himself. . . . It is not the satisfaction of a need, but only a means for satisfying other needs. (Bottomore, 1963, pp. 124-125)

Powerlessness

The historic relationship of powerlessness to man in sociological theory had its beginnings in Marxism and is now over a century old. The Marxian view of powerlessness focused on the exclusion of individual freedom and control in society. Marx's (1956/1964) aim was directed toward development of a society in which men would be the "measure of their own destiny, through their understanding and control both of nature and of their own social relationships" (p. 28). Marx's idea was a reflection of the 19th century thoughts of progress. Marx (1956/1964) identified alienation as the "fundamental evil of capitalist society" (p. 27).

Powerlessness was identified by Hegel (cited in Marcuse, 1941) and Marx (1956/1964) in interpreting workers' helplessness and isolation from control over their economic situation and future. Weber (cited in Gerth & Mills, 1946) examined powerlessness in the framework of work separation. Weber (cited in Gerth & Mills, 1946) noted that in industrial society, the laborer was without adequate control with regard to his economic future. Likewise, other workers and professionals such as civil servants and scientists were also subject to

powerlessness. However, Seeman (1967a, 1971) asserted that powerlessness in the work sector did not always or consistently produce the historically attributed personal consequences, such as political withdrawal or social movements as earlier proposed by Marx. Seeman's (1959) view of powerlessness departs from that of Marx in omission of the aggressive controversial component in the idea.

Alienation

Marx (1956/1964) saw alienation as a "condition in which man's own powers appeared as self-subsistent forces or entities controlling his actions" (p. 4). Marx devised a critical social theory with alienation as a major component and advanced the point of view of social determinism. Marx (1956/1964) and Deutsch and Krauss (1965) contributed to the decline in the belief of instinctively caused behavior. The importance of learning capacity, the opportunity inherent in brain growth, and social factors all render the notion of identifying behavior in man as strictly instinctive insufficient (Kolb, 1973).

Seeman (1959) drawing on works by Marx (cited in Seeman, 1959), Weber (cited in Gerth & Mills, 1946),

and Mills (cited in Seeman, 1959) identified alienation as having "five alternative meanings . . . powerlessness, meaninglessness, normlessness, isolation, and self-estrangement" (p. 783). Powerlessness is cited as the most common meaning of the concept alienation. The problem of alienation as powerlessness is prominent in classic and modern sociology (Seeman, 1959). Seeman (1972) noted that the "structure-alienation-behavior triad has rarely been incorporated in a given work . . . and remains largely inferential" (p. 515). Studies of powerlessness have largely been focused on a problem theme.

Hegel (cited in Marcuse, 1941) contributed to Marx's idea of alienation. Hegel first instituted the term "alienation" in characterizing man and man's separation in society. Man's knowledge was a major concept in Hegel's description of alienation. Marx (1956/1964) developed the idea of alienation beyond encompassing not only knowledge, but also man's position and sense of power in the labor situation. Seeman (1971) identified low knowledge as being associated with high powerlessness.

Dean (1961) noted a minor positive correlation of powerlessness and advancing age. Riley and Foner (1968) suggested that geriatric individuals, when compared to younger individuals, exhibited less of a sense of mastery in their own lives. Dean (1961) identified alienation as powerlessness and reported a low but statistically significant negative correlation between powerlessness and occupational prestige, education, income, and rural background. Dean devised scales to measure powerlessness, as well as normlessness and social interaction, to derive a total alienation score.

Several Likert-type powerlessness measures that provide a diverse means for concept investigation have been developed during the past 3 decades. The measurement of powerlessness can allow for "speculation and imagination about as yet unrealized ways of achieving greater mastery, better work circumstances, or less deceptive social practices" (Seeman, 1972, pp. 514-515).

J. P. Clark (1959) noted that in social psychological literature the concept alienation was seen as useful but was loosely defined. However, psychological

literature primarily focuses on disorders versus health (Seeman, 1972). J. P. Clark (1959) defined alienation as the "degree to which man feels powerless to achieve the role he has determined to be rightfully his in specific situations" (p. 849). K. Clark (1965) studied powerlessness in relation to the ghetto situation. This study noted the prevalence of powerlessness and feelings of total helplessness evident in the ghetto setting. Bullough (1967) examined segregated versus integrated blacks in the Los Angeles housing area. Blacks who had moved into integrated housing demonstrated decreased powerlessness. Seeman (1972) offered an explanation of this phenomenon by proposing that the powerless individual was not likely to engage in planned, instrumentally oriented action.

The Effects of Powerlessness and Alienation on Society and the Individual

In a computer search on the literature which focused on powerlessness and alienation in the geriatric population and in relation to preventive health behavior and attitudes, 16 citations were identified. However, no research study was located specifically in relation to powerlessness behavior in the geriatric individual.

Roy (1978) also studied powerlessness in relation to decision-making in the physically ill individual in hospital settings. This researcher reported that increased levels of decision-making, in certain individuals, decreased reported powerlessness. The groups demonstrating a correlation between situational powerlessness and decision-making were younger patients and those with short-term illnesses. Generalized powerlessness was affected by decision-making in the middle-aged individuals and those with short-term illness. Roy (1978) also reported no correlation of powerlessness in an individual's ability to cope with physical illness, and only a minimal relationship of powerlessness to psychosocial adaptation.

Nettler (1957) identified alienation as a psychological state of an individual and attempted to measure estrangement as a component of alienation. J. P. Clark (1959) agreed with Nettler's (1957) view of alienation as a psychological state. Whether social or psychological, the antecedents to powerlessness also vary among individuals (Otto & Featherman, 1975). Seeman (1972) noted that:

> Present evidence would suggest that, in the United States at least, the pattern of powerlessness appears to be more generalized than one might have supposed to be the case. (p. 522)

Otto and Featherman (1975) studied social and psychological antecedents of powerlessness. Their study explored early career powerlessness over a 15-year period. Otto and Featherman identified that adult social integration significantly decreased the individual's perceived sense of powerlessness. Otto and Featherman (1975) defined powerlessness as a "feeling of exposure and vulnerability" (p. 703). These researchers discovered that higher prestige occupations produced a sense of control and that powerlessness within an occupation could be derived from income and education.

Seeman (1967a) examined the results of alienation in work in a study consisting of a random sample of male workers in Sweden. This study failed to yield any strong direct correlation of perceived powerlessness to work. Seeman's study did, however, reveal a relationship of high powerlessness and low political knowledge. A further finding was that of powerlessness relevance to ethnic prejudice. Seeman (1967a) proposed:

> people whose work provides little opportunity for decision on the job will see their world as being more generally unmanageable. They will perceive themselves as being relatively powerless to affect a wide range of social and personal outcomes. (p. 274)

Neal and Seeman (1964) examined membership in labor union organizations and identified consistent association with lower scores on a powerlessness scale. The powerlessness scale is relevant to mass society in regard to control over ideological factors such as the economy and international affairs. The study indicated that membership in work-related organizations paralleled a high feeling of control. Thus, powerlessness was identified as not only a function related to socioeconomic position. The powerlessness perception was noted in organizational membership both as a motivational element in the determination to join and as a result of the organization's framework of support (Neal & Seeman, 1964). Seeman, 1967b) delineated that political knowledge was significantly associated with powerlessness perception. However, knowledge concerning culture and the arts was not significantly related to powerlessness perception.

Otto and Featherman (1975) identified powerlessness as referring to an individual's "perceived inability to

control his fate which renders him uncomfortable and may manifest itself in psychosomatic symptoms" (p. 703). Maslow (1954) in looking at the healthy personality, identified that some degree of powerlessness was a characteristic of the totally functional individual in society. However, Nettler (1957) and Dean (1961) noted that the individual's imperfect integration with society could develop into an almost complete emotional separation from society. Nettler (1957) asserted that the concept of powerlessness should not be identified as personal disorganization or intrapersonal goalless attitudes or beliefs.

Powerlessness creates isolation. The outcome of powerlessness is rooted in an individual's lack of accessibility to systems of interaction, information, and idea exchange of overall society. Isolation, as a consequence of powerlessness, restricts the cohesiveness between expectations, goals, and resources available to the individual (Otto & Featherman, 1975; Seeman, 1967b). Seeman (1972) identified the powerless individual as ready to participate in unplanned or short-term protect activities.

The association of action and powerlessness perception was further linked in a study by Ransford (1968).

Ransford studied a group of Negroes in the Watts area of California to determine the characteristics of individuals prone to commit violence. This researcher found that those individuals who felt isolated from society and powerless were more prone to commit violence than those with feelings of ties to the community. Seeman (1972) suggested a correlation between disadvantaged minorities and powerlessness. The blacks sampled showed greater powerlessness regardless of the population or measurement utilized (Seeman, 1972).

The principle of social learning has a definite impact on the generalization of powerlessness. The generality of powerlessness, as based on behavior and outcome control, will vary depending on the behavior and situation included (Seeman, 1959). Seeman asserted that it was one matter to feel powerless with regard to international affairs, but quite another to feel powerless in personal relationships. Social learning theory asserts three major factors as essential to make decisive forecasts: (a) a situation representation, (b) identification of individual expectancies, and (c) individual personal values (Seeman, 1972). Seeman also proposed that the principle of social

learning played a definite role in the development of powerlessness and could be identified in the work or job market. Powerless workers

> learn that they are objects of control by others, and this learning is applied to a wider range of socio-political affairs in which a sense of powerlessness is displayed. (Seeman, 1967a, p. 284)

Situational variables affect the predictions of outcomes of powerlessness (Seeman, 1972). In Seeman's (1963, 1972) studies of social learning in a reformatory, it was identified that no particular situation would produce the negative effect of powerlessness on learning. Significantly better learning regarding prison procedures was associated with powerlessness in short-term prisoners. Powerlessness had no effect in prisoners with long terms yet to be served. Powerlessness was seen as situationally more relevant to the short-term prisoners (Seeman, 1972).

Roy (1978) noted that lowered powerlessness provides for increased capable activity and improved learning. Rotter's (1966) study of social learning identified man's behavior as a result of choices. The significance of the reinforcement, and the expectancy that a given behavior in a given situation will

be successful, determines the choice, and therefore, which behavior occurs (Rotter, 1966). However, Seeman (1972) suggested that very little significance is predictable from expectancies alone.

Phares' (1957) study attempted to identify the results of situational variables on expectancy changes. This study utilized a sample of female college students (n = 77). Phares' study was based on social learning theory. Expectancy changes were identified as greater in a skill situation; such as, a situation that is related to an individual's performance versus chance situation (Phares, 1957).

Information allowing an individual mastery and control in a realistic situation was found in social interaction (Otto & Featherman, 1975). Social interaction in itself, however, does not deliver an individual with meaning in life. Social change is "regularly an implication, not a direct focus of investigation" (Seeman, 1972, p. 515) in powerlessness studies.

Seeman (1972) reported the following propositions:

1. The powerless person is not likely to participate in "planned, instrumentally oriented action" (p. 478).

2. The powerless are seen as more apt to engage in relatively unplanned and/or short-term protest activities than are their counterparts.

3. Low powerlessness is related to membership and activity in control oriented organizations.

4. Individuals with perceived powerlessness exhibit diminished learning of control-related knowledge in society.

5. More perceived powerlessness is identified in blacks and other minorities than comparable whites.

Mass Society Theory

The concept of mass society states that organizations that arbitrate between a state and an individual impede the growth and development of powerlessness (Neal & Seeman, 1964). Organizational membership is significant as an antecedent to powerlessness. The mass society supposition identified prevailing social practices such as population mobility, deterioration of extended family ties, and the appearance of massive bureaucracies as separating individuals from origins of control and satisfaction (Ransford, 1968).

Feldman and Hurn (1966) studied modernization and its effects on powerlessness. Heads of households (n = 104) were interviewed in Puerto Rico. Feldman and Hurn reported that the subjects, after a period of 10 years, exhibited decreased powerlessness and increased optimism regarding their chances in a modern and mobile society.

Seeman's (1967a) work with powerlessness and mass society theory provided the groundwork for a three-part scheme consisting of (a) social framework, (b) powerlessness consequences, and (c) attitude and behavior outcomes. The theory of mass society assists in providing a basis in which to study the effects of powerlessness.

Preventive Health Behavior and the Elderly

Riley and Foner (1968) identified preventive health behavior of geriatric individuals as being affected by the following factors: (a) individual's view of illness prevention and perception as to whether medical intervention can help in illness prevention, (b) individual's attitude toward health care facilities and professionals, (c) individual's sense of isolation or

powerlessness, and (d) socioeconomic status. Colcord (1930) described preventive health care as the consequence of procedures which included research, treatment, public education, and legislation. Kutner's (1956) study of individuals who were 60 years of age or older suggested little difference in utilization of health services when health status and isolation were controlled.

A multidisciplinary study by Butler (1968) produced data to suggest that many of the obvious indications and evidence previously contributed to aging revealed instead physical illness, personality changes, and many social-cultural consequences. According to Cath (1965), perception and cognition are related to reality orientation and feedback and can determine an elderly individual's view of what is "real." Botwinick (1973) further noted that:

> Without formal definition, and without intent, the lawmakers have defined old age for us. It is 65 years of age. Most people in this country become eligible for retirement with social security benefits at this age, and this legal decision has great import in our lives. Attitudes and expectations are formed on this basis, and it would not be unreasonable to believe that many people become old because they and the world around them have adopted such definition. (p. 1)

Botwinick (1973) generally characterized the elderly as being poor, living in urban areas, and at home. Brown, Haas, and Stevens (1978) found 83% of the men and 58% of the women in their study living in family settings; the majority of the other elderly were living alone. Only 5% of the elderly lived in institutions. Contrary to contemporary belief, the "elderly are not a homogeneous entity" (Bonwinick, 1973, p. 6).

The elderly individual suffers from doubts and questions related to health, mental and physical capabilities, and relationships with others. The elderly experience fear of becoming a burden and what will happen to them in the future (Botwinick, 1973; Cath, 1965). Cath (1965) asserted that "living sufficiently long in itself, brings inevitable personal loss, psychic and bodily depletion, and disease" (p. 190).

According to Leavell and Clark (1958), preventive health activities encompass (a) health promotion, (b) specific protection, (c) early diagnosis and treatment, (d) disability limitation, and (e) rehabilitation. Geriatric individuals tend to view health deteriorations as inevitable and seek palliative rather than

remedial or preventive care (Botwinick, 1973; Riley & Foner, 1968). Riley and Foner's (1968) study suggested that prevention of disease steadily declined with age. The elderly were identified as less likely to (a) engage in bodily exercise (Back & Gergen, 1966a); (b) obtain regular preventive dental care (Friedson & Feldman, 1958); (c) exhibit interest in nutritional care (Back & Gergen, 1966b); and (d) participate in flu immunization programs (Riley & Foner, 1968).

Dunn's (1961) philosophy of high-level wellness stressed aging as a portion of the growth process. This specific concept has been defined as an integrated method of functioning aimed at maximizing the potential of which the individual was capable. The individual is required to maintain a sequence of equilibrium and intentional direction within the individual's environment. The high level of wellness concept is useful in studies of the elderly and infers more than just the meeting of the elderly's basic needs by health care providers. The implementation of health maintenance and preventive measures to develop a higher functional potential is indicated.

Attitudes and Beliefs

Dillehay (1965) suggested that attitudes and beliefs played a definite and significant role in experience and behavior. Knutson (1965) proposed that:

> values, attitudes, and beliefs have a prevading influence over all of man's behavior. When strongly held, they contribute to social, industrial, and personal harmony, efficiency and well-being, or conversely, to conflicts that directly end in the death or disability of members of society. Their many indirect influences on man's behavior, while less spectacular and obvious, are often of equal significance. (p. 259)

Values, attitudes, and beliefs can vary according to sociocultural group, age, sex, occupation, and other factors (Dillehay, 1965; Knutson, 1965). Attitudes and beliefs influence behavior, but it should be realized that these factors are only segments of those affecting the individual's behavior. Conditions suggested in legal incumbancy, social constraints and expectations, and other factors can influence behavior (Dillehay, 1965; Rokeach, 1970).

Inkeles (1960) demonstrated a cross-cultural consistence in the correlation between status position and one's own set of attitudes and values. Roy (1978)

identified that "social structural conditions lead to given attitudes, sentiments, or internal states which then have specific behavioral consequences" (p. 9).

An attitude may be defined as:

> an organized predisposition to think, feel, perceive, and behave toward a referent or cognitive object. It is an enduring structure of beliefs that predisposes the individual to behave selectively toward referents. (Kerlinger, 1973, pp. 495-496)

One notion held by social psychologists and sociologists is that attitudes are inferred from behavior; another view has suggested that behavior may determine attitudes (Allport, 1935; Dillehay, 1965; Knutson, 1965). However, it should be noted that an individual may state an attitude or value different from that which significantly directs that individual's behavior (Dillehay, 1965; Knutson, 1965).

Three major aspects of attitude are as follows: (a) perception of an object, (b) subjective emotional feeling, and (c) behavioral predisposition (Allport, 1935). Dillehay (1965) further identified the concept of attitude as the "tendencies to experience or act toward an object in a way indicating some degree of favorableness-unfavorableness toward that object" (p. 294).

There are many different methods to assess attitudes that may be pertinent to research. Utilization of an instrument that elicits an individual's thoughts and subjective feelings on a subject may provide a means of measurement (Krech, Crutchfield, & Ballachey, 1962; Thurstone, 1928). Behavioral sciences have utilized attitudes and beliefs to interpret such manifestations as motivation, judgment, forgetfulness, learning, and perception. An individual's social and personal values and attitudes toward other persons and things and one's own beliefs concerning oneself and the surrounding environment may direct and limit that individual's health behavior (Kelman, 1974).

Summary

In the area of powerlessness research, the historical significance of alienation has been discussed. Both situational and personal powerlessness approaches have been presented. Alienation in theory, research, and practice has been reviewed and a conceptualization of alienation and powerlessness provided. The literature suggests a variance of antecedents and consequences of powerlessness. Studies in the area of

identifying antecedents of preventive health behavior in the geriatric person with a correlation to powerlessness has not been reported, and represents a void.

Organizational membership is delineated as an important influence to powerlessness. Mass society theory suggests that perceived powerlessness is related to organizations that mediate between the individual and a large institution or bureaucracy. Factors were identified that affect preventive health behavior in geriatric persons. The significant correlation of attitudes and beliefs to behavior has also been provided.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This study was classified as survey and descriptive correlational in design. According to Polit and Hungler (1978), a descriptive correlational study will "describe existing relationships without fully comprehending the complex causal pathways that exist" (p. 185) and, therefore, are limited by having "no control over the independent variables" (p. 185). The two variables in this study were the geriatric individual's powerlessness perception and the reported preventive health behavior.

Setting

The study was conducted at two senior citizens centers in the Southwestern United States. The centers provided a variety of social services, education, recreation, and health and nutritional activities to both males and females who were 60 years of age or older. Services were provided 5 days a week for at least 4 hours a day. Daily attendance was approximately

50-90 individuals per center. The centers, located in lower to lower-middle socioeconomic areas, are supported by federal and local funding.

Population and Sample

The population for the study consisted of geriatric individuals who were 65 years of age or older. The sample for this study consisted of a minimum of 40 geriatric individuals, both males and females, 65 years of age or older. The first 20 subjects at each senior citizen center, who consented to participate in the study, comprised the sample. The sample was considered accidental with subject selection based on availability or convenience.

Protection of Human Subjects

This study was exempt from the Human Subject Research Review Committee approval (Appendix A) because the study was survey research and presented no risk to the participants. Agency permissions for conducting the study were obtained (Appendix B) and permission was received from the graduate school (Appendix C). The following steps were taken to protect the rights of the subjects:

1. A verbal explanation of the study (Appendix D) was provided delineating the general purposes of the study.

2. There was voluntary participation with the verbal acknowledgement that withdrawal from the study was permitted at any time during the study.

3. The verbal explanation described the potential risks and benefits of participation in the study. The potential risks and benefits were read prior to the distribution of the instruments.

4. Subjects were offered an opportunity to obtain the results of the study upon completion.

5. The instruments did not include subjects' names, therefore anonymity was protected.

6. The completion and return of the instrument to the investigator constituted the subject's informed consent to participate in the study. This statement was included on the instruments.

Instruments

Two instruments were utilized in this study. These were the Demographic Data Form (Appendix E) and the Health-Illness Questionnaire (Appendix F). The two instruments were typed in enlarged print for

more appropriate use by the elderly with diminished vision.

Demographic Data Form

The Demographic Data Form was developed by the investigator and was used to gather information regarding the age, ethnic group background, income, and education of the subject. These data were used to describe the sample.

Health Illness Questionnaire

A fixed-alternative questionnaire adapted from Roy's (1978) Health-Illness (Powerlessness) Questionnaire (Appendix G) was utilized. The instrument was changed in wording from Roy's instrument in its deletion of the hospital setting focused context, the rearrangement of the format, and the addition of two items. The instrument used in the study consists of 20 Likert items. The first section of the questionnaire, items 1-10, are identified as powerlessness perception statements and deal with attitudes regarding control over illness and trait powerlessness. Items 1, 5, and 10 are stated in a positive direction, and items 2, 3, 4, 6, 7, 8, and 9 are stated in a negative direction or

reversed. The instrument was scored by giving weights of 1, 2, 3, and 4 to responses. Therefore, each item response received points ranging from 1-4. The higher numerical index was given to the response which indicated a higher perception level of powerlessness. The response weights were added to determine the score. The range of scores is 10-40. A higher score indicated a higher perception level of powerlessness; that is, the subject perceives that outcomes and circumstances are not within one's own control. For example, if all 10 questions were answered with a low powerlessness perception response, the score on each item would be 1 for a total score of 10. However, if all responses were high in powerlessness perception, then the total score was 40.

The second section, items 11-20, of the questionnaire was composed of 10 preventive health behavior items. The items in general relate to disease prevention, health promotion, and health maintenance. Items 11-16 and 18-20 are stated in a positive direction, and item 17 is negative or reversed. The questionnaire was scored by giving weights of 1, 2, 3, and 4 to responses. The response weights on each item statement

were added to determine the reported preventive health behavior score. The range of scores is 10-40. For example, if all 10 questions were answered with a low preventive health behavior response, the score on each item was 1, for a total score of 10. However, if all responses were high in preventive health behavior, then the total score was 40. A higher score defines a higher level of reported preventive health behavior.

The following steps were implemented in obtaining validity and reliability of the instrument:

1. A panel of five experts reviewed the instrument to determine content validity. The panel of experts included two registered nurses, who are geriatric nurse practitioners with Master's of Science degrees in nursing and currently practicing privately and in senior citizen centers; one Master's degree prepared social worker, working with geriatric individuals in a large county hospital; and two registered nurses, who are geriatric nurse practitioners (one with baccalaureate degree and one Master's of Science degree in nursing educational background), actively involved in community health nursing with a health department. Minor wording and phrasing changes recommended by this

panel of experts were instituted and content validity established.

2. According to Polit and Hungler (1978), the

> reliability of an instrument is not a property of the instrument, but rather of the instrument when administered to a certain sample under certain conditions. (p. 425)

Prior to data collection, a pilot study was done to derive reliability of the instrument developed by the investigator. A pilot study was completed utilizing 20 geriatric individuals attending a senior citizen center. A copy of the trial instrument used in the pilot study is shown in Appendix H. The instrument was given to 20 geriatric individuals at a senior citizen center. Outcomes of the pilot study revealed no significant adjustments in the data gathering procedure. However, pilot study responses to the instrument were correlated to determine a numerical index of instrument reliability. Instrument reliability was determined as 0.73 on the 10 powerlessness items and 0.52 on 7 preventive health behavior items. Low reliability on the preventive health behavior items was based on too few items and the wording of three items. These three items were revised for use in the final instrument. The additional consultation of a registered dietitian, with a

doctorate, who practiced in a community health agency, was obtained in item revision. The time period for administration of the instrument in the pilot study was approximately 4-17 minutes.

3. Instrument reliability was determined by coefficient alpha testing. Reliability on the 10 powerlessness items is 0.63 and 0.60 on the 10 preventive health behavior items (Appendix I).

Data Collection

The final adapted version of the Health-Illness Questionnaire was administered to the sample consisting of geriatric individuals who were 65 years of age or older. Prior to the administration of the instrument, a verbal explanation of the general purposes, the possible benefits, and risks of participation was given to the subjects. Subjects were assured of anonymity and given information on obtaining results of the study. The instrument was administered to 40 geriatric individuals, 65 years of age or older, attending two senior citizen centers. Completion and return of the questionnaire was construed as informed consent to participate in the study.

Treatment of Data

The variables of the geriatric individual's perception level of powerlessness and preventive health behavior were measured. The analysis of product moment correlation coefficient or Pearson *r* was used to test the hypothesis. The null hypothesis and the two-tailed procedure were used.

According to Polit and Hungler (1978), the Pearson *r* coefficient is "computed when the variables being correlated have been measured on either an interval or ratio scale" (p. 531). This index shows a relationship between the two variables, perception level of powerlessness and preventive health behavior of geriatric individuals. For purposes of this study, the level of significance was set at .05.

CHAPTER 4

ANALYSIS OF DATA

A descriptive correlational study was conducted to determine if there were relationships between two variables: perception level of powerlessness and reported preventive health behavior. The significance of the relationship between the two variables has been established through use of Pearson's product-moment correlation. The analysis of data collected through utilization of the Demographic Data Form and the Health-Illness Questionnaire is presented in this chapter. A total of 40 geriatric persons participated in the study. A quantitative description of the sample is provided in narrative and table format. The findings are presented and summarized in narrative and figure arrangement.

Description of Sample

The sample consisted of 40 volunteer geriatric persons, 65 years of age or older, attending two senior citizen centers in the Southwestern United States. The

demographic data regarding age and education of the 40 geriatric persons composing the sample are shown in Table 1. The mean and standard deviation as well as the minimum and maximum are shown for the variables of age and education. The mean age of the subjects was 78.2 years with a range of 65-94 years. The average years of education were 10.6 years with a range of 2-18 years. Sixty percent of the subjects had 12 years or more of education.

Table 1

Demographic Data of Age and Education of Sample

Variable	$\bar{X}$	SD	Min.	Max.
Age	78.275	7.470	65	94
Education	10.650	3.827	2.0	18.0

$n = 40$.

Table 2 illustrates the demographic data concerning ethnic group background and income of the sample. The number of individuals and percentage of the total sample in each variable category of ethnic group background and income are shown. Ethnic group background was 75% white,

Table 2

Demographic Data of Ethnic Group Background and Income of Sample

Demographic Category	Number	Percentage
Ethnic group backround		
White	30	75
Black	6	15
Spanish American	4	10
Other (including American Indian and Oriental)	0	0
Total	40	100
Income		
$249/month or less	7	17
$250-$499/month	21	53
$500-$749/month	8	20
$750/month or more	4	10
Total	40	100

15% black, and 10% Spanish American. The majority of subjects (53%) was in the $250-$499/month income level, with 17% in the $249/month or less, 20% in the $500-$749/month, and 10% in the $740/month or more categories.

Findings

Data derived from the written questionnaire yielded two scores for each of the 40 subjects: a perception level of powerlessness score and a reported preventive health behavior score. The powerlessness perception score was obtained by adding the cumulative number of points assigned to each item statement.

The hypothesis stated that there would be no significant relationship between perception level of powerlessness and reported preventive health behavior of geriatric individuals. Polit and Hungler (1978) identified that "a negative relationship is one in which high values on one variable are related to low values on the other" (p. 529). The results of the analysis of data indicated a significant negative relationship in geriatric individual's perception level of powerlessness and their reported preventive health

behavior. The hypothesis was tested using Pearson's product-moment correlation coefficient. Pearson's product-moment correlation coefficient was determined to be $r = -0.361$, $p = .021$. Therefore, the hypothesis was rejected. A negative r indicates that high perception level of powerlessness scores are associated with low reported preventive health behavior scores and low perception level of powerlessness scores are associated with high reported preventive health behavior scores. Figure 1 illustrates graphically the relationship of perception level of powerlessness to reported preventive health behavior.

The sample mean on the powerlessness perception scale was 23.75, with a standard deviation of 4.0. Therefore, the sample demonstrated a relatively low perception level of powerlessness and a homogeneous response with a narrow variance in scores. The mean on the reported preventive health behavior scale was 33.20, with a standard deviation of 3.8. The study sample demonstrated a high reported preventive health behavior with a homogeneous response and narrow variance in scores.

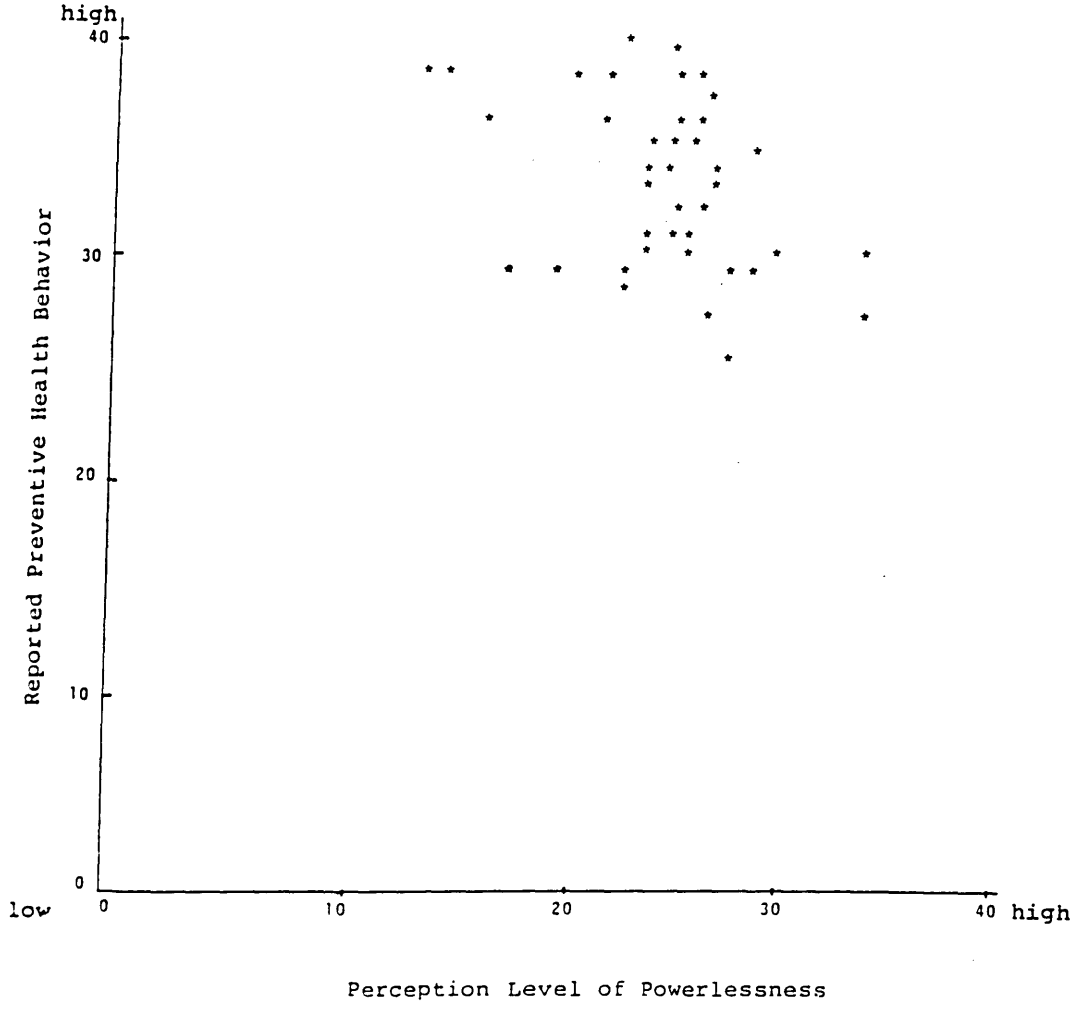

Figure 1. Scatterplot of reported preventive health behavior and perception level of powerlessness.

Additional Findings

Multiple regression analysis was computed applying other data factors obtained on the Demographic Data Form to the perception level of powerlessness and reported preventive health behavior. In the analysis of data utilizing perception level of powerlessness as the dependent variable, the results were significant in the relationship of powerlessness perception to ethnic group background, $R = .47$, $p = .01$.

The coefficient of determination was 22%. Twenty-two percent of the variance in powerlessness perception was predictable based on ethnic group background. This indicates that nonwhites have a higher perception level of powerlessness than whites. The present study sample consisted of 25% nonwhites.

The regression equation is as follows:

$$\text{perception level of powerlessness} = -.361 \times \text{PHB} + 2.98 \times \begin{matrix}(1\text{—if white}) \\ (2\text{—if nonwhite})\end{matrix} + 32.14$$

No significant relationship was found between age, income, or education and perception level of powerlessness, or age, income, ethnic group background, or education and reported preventive health behavior.

An additional finding related to the instrument reliability. Reliability of the 10-question instrument on perception level of powerlessness was 0.63. It was found that Question #1 was not as reliable as the other 9 questions. If item Question #1 were deleted from the questionnaire, the reliability on the perception level of powerlessness is 0.71. Recalculation of the Pearson's product-moment correlation coefficient showed that the relationship between preventive health behavior increased slightly, $r = -.39$, $p = .013$.

Summary of Findings

Analysis of data obtained from the 40 geriatric persons composing the sample demonstrated a significant negative relationship between perception level of powerlessness and their reported preventive health behavior as measured by scores on the Health-Illness Questionnaire. One demographic factor was associated with a statistically significant finding. There was a significant relationship demonstrated between perception level of powerlessness and ethnic group background, with higher perception level of powerlessness predicted in nonwhites ($R = .47$, $p = .013$). Neither age, income, or

education was associated with any significant relationship to the perception level of powerlessness scores. Additionally, no significant relationship was demonstrated between age, ethnic group background, income, or education and reported preventive health behavior scores.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter of the study will provide a summary of the research methodology utilized. In addition, a discussion of the findings, conclusions and implications, and recommendations for further study will be presented.

Summary

The problem of this descriptive correlational study was to determine the relationship of perception level of powerlessness to reported preventive health behavior in geriatric persons 65 years of age or older. The conceptual framework of powerlessness utilized in this study is a component of alienation. Seeman's studies provided the basis for utilization of powerlessness in the present study. An adaptation of Roy's (1978) Health-Illness (powerlessness) Questionnaire and a researcher-developed Demographic Data Form were used for collection of data. The hypothesis stated that there would be no significant relationship between perception level of powerlessness and reported

preventive health behavior of geriatric individuals. Based on the analysis of data, the hypothesis was rejected.

Data were collected from a sample composed of 40 geriatric persons, 65 years of age or older, attending two local and federally supported senior citizen centers located in the Southwestern part of the United States. Data were collected utilizing two instruments: an adaptation of Roy's (1978) Health-Illness (Powerlessness) Questionnaire and a researcher developed Demographic Data Form. Subjects were informed that completion and return of the questionnaires would be construed as informed consent to participate in the study. The instruments were administered to the subjects during a 2-week period in the Winter of 1982.

Subjects' scores on the Health-Illness Questionnaire were determined and Pearson's product-moment correlation coefficient was computed to test the hypothesis. In addition, the perception level of powerlessness and reported preventive health behavior were analyzed using the demographic data information regarding age, ethnic group background, income, and education.

Analysis of data demonstrated a statistically significant negative relationship between perception level of powerlessness and reported preventive health behavior. The hypothesis for the study stated that there would be no significant relationship between perception level of powerlessness and reported preventive health behavior of geriatric individuals. The Pearson's product-moment correlation coefficient showed a significant (r = -0.361, p = 021) negative correlation between perception level of powerlessness scores and the reported preventive health behavior scores. Therefore, the research hypothesis, tested by Pearson r, was rejected and a significant negative relationship was demonstrated between the perception level of powerlessness and the reported preventive health behavior of geriatric persons.

Discussion of Findings

Based on the findings of this study, the following discussion is provided:

Test of the hypothesis

The assertion that the perception level of powerlessness is related to reported preventive health behavior

was supported in the Health-Illness Questionnaire scores. The perception level of powerlessness and reported preventive health behavior were found to have a significant negative correlation. The product-moment correlation coefficient, Pearson r was -0.361 and the level of significance was 0.021. The relationship was moderately statistically strong, and has significant predictive value.

Additional findings. The variable of ethnic group background demonstrated a significant correlation to the perception level of powerlessness. The variables of age, education, and income contributed no predictive value to perception level of powerlessness. Therefore, no correlational conclusions based on this finding could be made. No significant relationship between age, education, ethnic group, background, and income and reported preventive health behavior was found.

In summary. The hypothesis that there would be no significant relationship between perception level of powerlessness and reported preventive health behavior of geriatric individuals was rejected. The present study demonstrated a significant negative

relationship between powerlessness perception and preventive health behavior as measured by the Health-Illness Questionnaire (r = -0.361, p = .021).

Perception Level of Powerlessness

Powerlessness and social integration. Otto and Featherman's (1975) study found that adult social integration effectively lowered an individual's sense of powerlessness. The geriatric persons participating in this study were involved in social interaction and exposed to information and a communication network at the senior citizen centers. The geriatric person's social involvement may have presented a factor in the response obtained on the Health-Illness Questionnaire. As in the Otto and Featherman study, the level of powerlessness perception in the present study was relatively low. The mean of the powerlessness perception scale of the present study was 23.75, on a range of 10-40.

Powerlessness and ethnic group background. Middleton (1963) and Lefcourt and Ladwig (1965) found a significant relationship of ethnic group background to powerlessness, as was found in the present study. Lefcourt and Ladwig found higher powerlessness among black inmates in two

correctional institutions (t = 2.89, p = .01). Therefore, minority membership was found to have a significant correlation to powerlessness. The present study was congruent with the findings of Middleton (1963) with a correlation between powerlessness perception and ethnic group background. In a community study, Middleton identified definite differences between blacks and whites in a central Florida city, with a higher percentage of blacks (70%, n = 99) indicated as powerless than whites (40%, n = 207).

The present study demonstrated a predictive value in accounting for 22% of the variance in powerlessness perception based on ethnic group background. The study sample consisted of 25% nonwhite, with 15% black. A higher perception level of powerlessness was demonstrated in nonwhites (R = .47, p = 0.01).

Powerlessness and education. Seeman and Evans (1962) found a relationship of powerlessness to knowledge and learning. High powerlessness related significantly to limited knowledge. Neal and Seeman's (1964) study reported a strong correlation between powerlessness and education. Dean (1961) reported a low but statistically negative correlation between powerlessness and educational

background. The mean educational background of the subjects in the present study was 10.6 years, with 60% having 12 years or more of education. However, no statistically significant correlation of education to perception level of powerlessness was reported.

Powerlessness and age. Neal and Seeman's (1964) study reported a significant correlation with powerlessness to age. Dean (1961) noted a minor positive correlation of powerlessness and age. The present study indicated no significant relationship of powerlessness perception to age.

Conclusions and Implications

The following were the conclusions of the present study:

1. The geriatric subject with a low perception level of powerlessness may be predicted to have a higher reported preventive health behavior.

2. Nonwhites would be expected to demonstrate a significantly higher level of powerlessness.

3. Findings of the present study supported the conceptual framework and studies identified by Seeman.

4. The Health-Illness Questionnaire would be of value if utilized by nurses in practice.

The findings and conclusions of this study have implications for nursing practice, nursing education, and nursing research. With 11% of the population being 65 years of age or older and the number of individuals in this category estimated to increase to 20% by the year 2030, nurses in health care facilities and the community may be increasingly involved in health care delivery to these individuals. An important component of providing care to the elderly individual is understanding the factors that affect their health behavior. Providing nursing practice with an expanded knowledge of the geriatric population should allow for nursing intervention to be planned to assist the elderly gain a higher quality of life. The powerlessness perception and the preventive health behavior portions of the Health-Illness Questionnaire could be utilized by nurses in practice to evaluate the perception level of powerlessness and preventive health behavior in the care and education of the elderly.

Implications for nursing education include teaching students the concept of powerlessness and antecedents to preventive health behavior. Students need to develop an awareness of the relationship between powerlessness

perception and health behavior in geriatric persons. Curriculum plans should encompass the role of the nurse in recognizing the interaction of powerlessness in the geriatric person's behavior. The implications for nursing research are in examination of the relationship of powerlessness to preventive health behavior. Studies measuring powerlessness and health behavior would add to the knowledge base concerning these variables.

Recommendations for Further Study

The following recommendations were offered for further research studies:

1. A study designed to incorporate the triad of structure situation-powerlessness-behavior for investigation.

2, Longitudinal study that examines the effects of societal changes on powerlessness perception and health behavior of geriatric individuals.

3. A comparative investigation of institutional versus community powerlessness perception and preventive health behavior of geriatric individuals.

4. Additional studies should be conducted using the newly developed Health-Illness Questionnaire, as this instrument has had limited research application.

APPENDIX A

Prospectus for Thesis
Approval Form

This proposal for a thesis by Paula Ann Key Loftis

and entitled Powerlessness Perception and Preventive Health Behavior of Geriatric Individuals

has been successfully defended and approved by the members of the Thesis Committee.

This research is xx is not _____ exempt from approval by the Human Subjects Review Committee. If the research is exempt, the reason for its exemption is: _____

Questionnaire research that presents no risks to study participants.

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX B

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Senior Citizens of Greater Dallas/Hospitality House Senior Center

GRANTS TO Paula A. Loftis
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Powerlessness perception in geriatric individuals and its relationship to preventive health behavior.

The conditions mutually agreed upon are as follows:

1. The agency (may) ~~(may not)~~ be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) ~~(may not)~~ be identified in the final report.
3. The agency (wants) ~~(does not want)~~ a conference with the student when the report is completed.
4. The agency is (willing) ~~(unwilling)~~ to allow the completed report to be circulated through interlibrary loan.
5. Other _____

_____

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To protect individuals we have covered their signatures.

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO Paula A. Loftis
a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Powerlessness perception and its relationship to preventive health behavior in geriatric individuals.

The conditions mutually agreed upon are as follows:

1. The agency (~~may~~) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (~~may~~) (may not) be identified in the final report.
3. The agency (~~wants~~) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (~~unwilling~~) to allow the completed report to be circulated through interlibrary loan.
5. Other _____

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX C

TWU Texas Woman's University
P.O. Box 22479, Denton, Texas 76204 (817) 383-2302, Metro 434-1757, Tex-An 834-2133
THE GRADUATE SCHOOL

January 28, 1982

Ms. Paula A. Key Loftis
8701 Stults Road
Dallas, TX 75243

Dear Ms. Loftis:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Dissertation/Theses signature page is here.

To protect individuals we have covered their signatures.

APPENDIX D

Verbal Explanation to Subject

I am Paula Loftis. I am a registered nurse studying the elderly and their attitudes. I have a questionnaire that I would like you to complete. There are no right or wrong answers. The questions are about what you think and do about health and illness. If you would consider answering these questions for me, you may be helping nurses to better understand and help the elderly.

The potential risks or discomforts to you in this study are only minimal risks or discomforts such as: (a) you may become tired when filling out the questionnaire, or (b) fear that others may see the completed questionnaire. You may rest if you become tired and may take as long as you like to complete the questionnaire. Your anonymity will be maintained. Please indicate to the senior citizen center manager if you would like to have a copy of the results of the study, an abstract. I will send a copy of the abstract to the center upon completion of the study if you so request.

If you have any questions regarding the study I will be glad to answer those questions. The completion

and return of this questionnaire will be construed as informed consent to participate in the study.

APPENDIX E

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

Demographic Data Form

1. Age:

   _____

2. Ethnic Group Background:

   _____ White
   _____ Black
   _____ American Indian
   _____ Spanish American
   _____ Oriental

3. Income:

   _____ $249/month or less
   _____ $250-$499/month
   _____ $500-$749/month
   _____ $750/month or more

4. Education:

   _____ Highest school grade completed.

APPENDIX F

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

Health-Illness Questionnaire

Below are some comments about health and illness. I am interested in knowing how you feel and what you do concerning these statements. There are no right or wrong answers. Please check the response that most nearly agrees with how you feel and what you do. Check only one answer in each set.

For example: The sun will rise tomorrow.
__X__ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

1. Luck has little or nothing to do with my getting well.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

2. Staying well depends on how much family and friends help you.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

3. I don't feel there is anything I can do to better my state of health.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

4. I have found that what is going to happen will happen, no matter what I do.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

5. Getting well depends a lot on what I do.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

6. Staying well depends only on God's will, not on what I do.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

7. It doesn't seem to matter what I say to the doctors and nurses, they go about their business in their own way.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

8. Good health is a matter of chance.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

9. I really don't have much control over what happens to me.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

10. I feel that I can do a great deal to keep myself well.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

11. I go to a doctor or nurse on a regular basis whether I am sick or not.
_____ Always
_____ Usually
_____ Infrequencly
_____ Never

12. I brush my teeth or care for my gums and mouth daily.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

13. Females--I do a breast self-examination.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

Males--I have a yearly rectal examination.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

14. I eat food three times a day.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSTRUED AS INFORMED CONSENT TO PARTICIPATE IN THIS STUDY.

15. I keep my home free of possible hazards (for example: long phone or extension cords, slippery rugs).
_____ Always
_____ Usually
_____ Infrequently
_____ Never

16. I get a yearly eye and ear examination.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

17. I use tobacco products.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

18. Exercise is included in my daily activities.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

19. I take medications regularly when prescribed by the physician.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

20. I eat meat or dairy products every day.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

APPENDIX G

HEALTH-ILLNESS QUESTIONNAIRE

Below are some comments about health, illness, and the hospital. I am interested in knowing how you feel about these statements. There are no right or wrong answers. Please check the response that most nearly agrees with how you feel. Check only one answer in each set.

For example: The sun will rise tomorrow.

__X__ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

1. Getting well in the hospital is a matter of the efforts of all of us; luck has little or nothing to do with it.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

2. It doesn't seem to matter what I say to the doctors or nurses, they go about their business in their own way.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

3. I don't feel there is anything I can do to better my condition.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

4. In the hospital I can be pretty sure that the nurses will listen to me instead of acting just out of routine.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

5. Getting well depends a lot on what I do.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

6. Getting released from the hospital depends on how lucky you are.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

7. I really don't expect to have much control over what happens to me in the hospital.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree

8. I now feel that I can do a great deal to keep myself well in the future.
   _____ I strongly agree
   _____ I agree
   _____ I disagree
   _____ I strongly disagree.

APPENDIX H

I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS STUDY.

HEALTH-ILLNESS QUESTIONNAIRE

Below are some comments about health and illness. I am interested in knowing how you feel and what you do concerning these statements. There are no right or wrong answers. Please check the response that most nearly agrees with how you feel and what you do. Check only one answer in each set.

For Example: The sun will rise tomorrow.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

1. Luck has little or nothing to do with my getting well.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

2. I doesn't seem to matter what I say to the doctors and nurses, they go about their business in their own way.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

3. I don't feel there is anything I can do to better my state of health.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

4. I have found that what is going to happen will happen, no matter what I do.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

5. Getting well depends a lot on what I do.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

6. Staying well depends only on God's will, not on what I do.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

7. Staying well depends on how much family and friends help you.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

8. Good health is a matter of chance.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

9. I really don't have much control over what happens to me.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

10. I feel that I can do a great deal to keep myself well.
_____ I strongly agree
_____ I agree
_____ I disagree
_____ I strongly disagree

11. I go to a doctor or nurse on a regular basis whether I am sick or not.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

12. If I have medications to take, I take them regularly.
_____ Always
_____ Usually
_____ Infrequently
_____ Never
_____ Not applicable, I have no medications

13. I brush my teeth or care for my gums and mouth daily.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

14. I eat meat or dairy products every day.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

15. Females--I do a breast self-examination
_____ Always
_____ Usually
_____ Infreqently
_____ Never

Males--I have a yearly rectal examination
_____ Always
_____ Usually
_____ Infrequently
_____ Never

16. Snack or "junk" foods are included as part of my diet.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

17. I keep my home free of possible hazards (for example: long phone or extension cords, slippery rugs).
_____ Always
_____ Usually
_____ Infrequently
_____ Never

18. I eat vegetables daily.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

19. I get a yearly eye and ear examination.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

20. I wash my hands after using the bathroom.
_____ Always
_____ Usually
_____ Infrequently
_____ Never

APPENDIX I

Instrument Reliability

Question	Mean	Standard Deviation	Alpha if Deleted
1. Luck has little or nothing to do with my getting well.	2.28	1.04	0.71
2. Staying well depends on how much family and friends help you.	2.265	1.00	0.52
3. I don't feel there is anything I can do to better my state of health.	2.53	0.93	0.56
4. I have found that what is going to happen will happen, no matter what I do.	2.83	0.93	0.51
5. Getting well depends a lot on what I do.	1.48	0.55	0.60
6. Staying well depends only on God's will, not on what I do.	2.88	0.94	0.56
7. It doesn't seem to matter what I say to the doctors and nurses, they go about their business in their own way.	2.20	0.79	0.50

Instrument Reliability (continued)

Question	Mean	Standard Deviation	Alpha if Deleted
8. Good health is a matter of chance.	2.20	0.79	0.50
9. I really don't have much control over what happens to me.	2.45	0.85	0.52
10. I feel that I can do a great deal to keep myself well.	1.60	0.55	0.58
11. I go to a doctor or nurse on a regular basis whether I am sick or not.	2.93	1.02	0.54
12. I brush my teeth or care for my gums and mouth daily.	3.65	0.74	0.59
13. Females--I do a breast self-examination. Males--I have a yearly rectal examination.	2.80	0.97	0.59
14. I eat food three times a day.	3.43	0.75	0.58
15. I keep my home free of possible hazards (for example: long phone or extension cords, slippery rugs).	3.40	0.78	0.55

Instrument Reliability (continued)

Question	Mean	Standard Deviation	Alpha if Deleted
16. I get a yearly eye and ear examination	3.40	0.78	0.55
17. I use tobacco products.	3.63	0.90	0.63
18. Exercise is included in my daily activities.	3.18	0.81	0.53
19. I take medications regularly when prescribed by the physician.	3.70	0.65	0.54
20. I eat meat or dairy products every day.	3.58	0.71	0.57

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